Critical Illness

The Critical Illness Plan pays a lump sum benefit that can be used to help cover out-of-pocket expenses related to eligible critical illnesses/diseases. Benefits are non-taxable and do not coordinate with other types of benefits an employee may receive. The Group Critical Illness Insurance Policy is underwritten by American Heritage Life Insurance Company, a subsidiary of the Allstate Corporation. Allstate Benefits is the marketing name for American Heritage Life Insurance Company.

Benefit Cost

The employee pays 100% of the cost post-tax. The cost of coverage will depend upon the coverage option selected by the employee.

Effective Date of Coverage

For full-time employees, coverage will be effective on the 90th day of continuous employment, and initial enrollment elections for coverage must be made within 60 days of date of hire or rehire. For part-time employees, coverage will be effective the day the coverage is elected, and initial enrollment elections for coverage must be made within 31 days of the date of hire or rehire.

Making Changes During the Year

Changes, such as, adding, dropping, increasing, or decreasing coverage under the Critical Illness Plan can only be made during Annual Enrollment or due to a qualified life event/status change.

Eligibility*

Employee; spouse; domestic partner**; and children up to age 26 regardless of full time student or marital status.

*Not available to part-time employees working in Minnesota and New Hampshire, and employees working or living in Massachusetts

**must meet eligibility conditions

Coverage Amounts

Coverage amounts are available in increments of $10,000 up to a maximum of $50,000.
Spouse/Domestic partner are 100% of the employee benefit and child(ren) coverage amounts are 50% of the employee benefit.

Definition of Critical Illness

The plan will pay a specified percentage of the Basic Benefit Amount selected for covered illnesses/diseases. Benefits continue until a maximum of 200% of the basic benefit amount is reached. The benefits that are payable under the Critical Illness Insurance Plan are:

Critical Illness	**Percentage of Basic Benefit Amount**
Heart Attack	100%
Stroke	100%
Coronary Artery By-Pass Surgery	100%
End State Renal Failure	100%
Cancer (Invasive Cancer)	100%
Cancer (Carcinoma in situ)	25%
Alzheimer's Disease, Major Organ Failure, Major Organ Transplant, Bone Marrow Transplant	100%
Addison’s Disease, Amyotrophic Lateral Sclerosis, Cerebral Palsy, Cystic Fibrosis, Diphtheria, Encephalitis, Huntington’s Chorea, Legionnaire’s Disease, Malaria, Meningitis (bacterial), Multiple Sclerosis, Muscular Dystrophy, Myasthenia Gravis, Necrotizing Fasciitis, Osteomyelitis, Poliomyelitis, Rabies, Scleroderma, Sickle Cell Anemia, Systemic Lupus, Systemic Sclerosis, Tetanus, Tuberculosis	25%

Exclusions

The Critical Illness Insurance Plan does not pay benefits for any critical illness due to, or resulting from (directly or indirectly):

- Any act of war, whether or not declared, participation in a riot, civil disorder, insurrection or rebellion; or
- Intentionally self-inflicted injuries; or
- Engaging in an illegal occupation or committing or attempting to commit a felony; or
- Attempted suicide, while sane or insane; or

- Being under the influence of narcotics or any other controlled chemical substance unless administered upon the advice of a physician
- Participation in any form of aeronautics except as a fare-paying passenger in a licensed aircraft provided by a common carrier and operating between definitely established airports; or
- Alcohol abuse or alcoholism, drug addiction, or dependence upon any controlled substance.

If a covered person has been recommended by a physician to have a major organ transplant prior to the effective date of the person's coverage, coverage for that transplant is excluded and no benefit will be paid for the transplant of that organ.

If a covered person has a disease or physical condition that meets the definition of pre-existing condition, a benefit will be payable for that disease or physical condition only if the date of diagnosis, as defined in this benefit, occurs more than 12 months after the effective date of his or her coverage. Pre-existing condition means any critical illness for which the covered person has sought medical advice or treatment in the 12 months immediately before the effective date of their coverage. No diagnosis is required for a pre-existing condition.

Plan Enhancements

Recurrence Benefit

Benefits will be paid at 50% of the First Occurrence Benefit for a reoccurrence of the same condition.

- The same condition is excluded for 180 days after prior occurrence
- The same condition is included except for incurable diseases
- The same form of cancer is included (must be symptom and treatment free for 180 days)
- Benefits are not payable for reoccurrence of:
    - Kidney Failure
    - Alzheimer's Disease
    - Adrenal hypofunction (Addison's disease)
    - Amyotrophic lateral sclerosis (ALS, Lou Gehrig's disease)
    - Cerebral palsy
    - Cystic fibrosis
    - Diphtheria
    - Encephalitis
    - Huntington's chorea

- Legionnaires' disease
- Malaria
- Meningitis (bacterial)
- Multiple sclerosis
- Muscular dystrophy
- Myasthenia gravis
- Necrotizing fasciitis
- Osteomyelitis
- Poliomyelitis
- Rabies
- Scleroderma
- Sickle cell anemia
- Systemic lupus
- Systemic Sclerosis
- Tetanus
- Tuberculosis

Waiver of Premium (Insured Employee Only)

The Critical Illness Insurance Plan will provide a waiver of premium while this coverage is in force, if you become disabled due to a critical illness for which an Initial Critical Illness Benefit has been paid and remain disabled for 90 days. The Plan will pay premiums due after such 90 days for as long as you remain disabled. If you are employed at the time of disability, the Plan will pay premiums for the first 365 days if you are unable to work at your own occupation; and then after 365 days if unable to work at any occupation. If unemployed at the time of disability, you must be unable to perform 2 or more activities of daily living for 90 consecutive days. You must not be working at any job for pay or benefits while premiums are waived.

Wellness Benefit

A benefit of $75 per calendar year, per covered person, is paid when an eligible test is performed, after the member's coverage has been in force for 30 days. The test must be performed under the supervision of or recommended by a physician, while coverage is in force, and a charge must be incurred. This benefit is paid regardless of the result of the test. Eligible tests are as follows:

- One routine immunization per year for diphtheria, tetanus, pertussis, polio, rubella, mumps, measles, HIB, hepatitis B, chicken pox, meningococcal disease
- One routine immunization per year during the first 24 months of life to prevent invasive pneumococcal disease
- One routine immunization per year during the 6th through the 23rd months of life to prevent influenza
- One inpatient visit for routine newborn care
- One routine cervical cancer screening a year for females
- One baseline mammogram for females ages 35 to 39
- One mammogram per year for females ages 40 and over
- One prostate specific antigen test per year for males dialysis ages 35 and over
- One cholesterol test every five years
- One routine sigmoidoscopy every three years for age 50 and over
- One routine hemocult stool check each year for ages 50 and over
- One double-contrast barium enema every five years for age 50 and over
- One colonoscopy every 10 years for age 50 and over
- One routine lab test to include a complete blood count, urinalysis, and TB skin test when performed with a routine office visit
- One office visit for the first six years of a baby's life
- One routine office visit every 12 months
- One routine Gynecological Care Exam each calendar year for female members

The following tests qualify for a Wellness Benefit to be paid under all Options shown above. Participants must be enrolled in the product for 30 days before they are eligible for the Wellness Benefit:

- Biopsies for Cancer
- Bone Marrow Testing
- Blood Tests for Triglycerides
- CA15-3 (cancer antigen 15-3 blood test for breast cancer)

- CA125 (cancer antigen 125 blood test for ovarian cancer)
- CEA (carcinoembryonic antigen-blood test for colon cancer)
- Chest X-ray
- Carotid Doppler
- Doppler screening for peripheral vascular disease
- Doppler screening for cancer
- Electrocardiogram/Echocardiogram
- HPV (human papillomavirus) Vaccination
- Serum Protein Electrophoresis (test for myeloma)
- Stress Tests on bike or treadmill
- Skin cancer biopsy
- Thermography
- Ultrasound screening of the abdominal aorta for abdominal aortic aneurysms

National Cancer Institute Evaluation

The Critical Illness Insurance Plan will pay the following benefit when a covered person receives an evaluation or consultation at a National Cancer Institute ("NCI") sponsored cancer center as a result of a previous diagnosis of a covered internal cancer:

1. $500 for the evaluation or consultation; and
2. $250 for the transportation and lodging of the covered person if the NCI-sponsored cancer center is more than 100 miles from the covered person's home.

The reason for such evaluation or consultation at an NCI-sponsored cancer center must be to determine the appropriate treatment for a covered cancer. This benefit is paid once per initial and recurrence diagnosis of invasive or carcinoma in situ cancer.

Transportation Benefit

The Critical Illness Insurance Plan will pay the actual cost, up to $1,500, for round trip transportation coach fare on a common carrier or a personal vehicle allowance of $0.50 per mile, up to $1,500, that is required for treatment of a covered critical illness at a hospital (inpatient or outpatient); or radiation therapy center; or chemotherapy or oncology clinic; or any other specialized free-standing treatment center. Mileage is measured from the covered person's residence to the treatment facility as described

above. The benefit will not be paid if the covered person lives within 100 miles one-way of the treatment facility. Allstate Benefits will not pay for: transportation for someone to accompany or visit the covered person receiving treatment; visits to a physician's office or clinic, or for other services. If the treatment is for a covered child and common carrier travel is necessary, we will pay this benefit for up to 2 adults to accompany the child.

Lodging Benefit

The Critical Illness Insurance Plan will pay $60 per day when a covered person receives treatment for a critical illness on an outpatient basis. The benefit is for lodging at a motel, hotel, or other accommodations acceptable to American Heritage Life Insurance Company. This benefit is limited to 60 days per calendar year. This benefit is not payable for lodging occurring more than 24 hours prior to treatment or for lodging occurring more than 24 hours following treatment. Outpatient treatment must be received at a treatment facility more than 100 miles one-way from the covered person's residence.

Non-Invasive Skin Cancer Benefit

The Critical Illness Insurance Plan will pay $250 if a covered person is diagnosed with skin cancer if:

1. the date of diagnosis is after the effective date of coverage; and
2. the date of diagnosis is while the policy is in force; and
3. it is not excluded by name or specific description in the policy.

This benefit is payable only once per covered person per calendar year.

Bone Marrow Stem Cell Donation Benefit

The Critical Illness Insurance Plan will pay $1,000 if a covered person donates bone marrow stem cells for the purposes of a bone marrow transplant or stem cell transplant, as defined in the policy, subject to all of the following:

1. the date of the donation is after the effective date of coverage; and
2. the date of donation is while insured; and
3. a benefit has not been paid for the covered person for the bone marrow stem cell transplant before.

This benefit is limited to 1 donation per covered person.

Filing Claims

Covered persons are encouraged to notify American Heritage Life Insurance Company of a claim as soon as possible so that a claim decision can be made in a timely manner. Notice of claim must be given within 60 days after the occurrence or commencement of any benefit covered by the policy, or as soon as reasonably possible. Notice can be given directly or on behalf of a covered person or the beneficiary at:

1776 American Heritage Life Drive
Jacksonville, Florida 32224-6687

or to any authorized agent of American Heritage Life Insurance Company, with your name and certificate number.

A claim form can be requested from American Heritage Life Insurance Company by calling 1-800-348-4489 or at www.AllstateBenefits.com/lowes. If it is not received within 15 days of the request, notice of the claim may be sent without waiting for the form. The claimant must complete his or her own sections of the claim form and then give it to the attending physician. The physician should complete his or her section of the form and send it directly to American Heritage Life Insurance Company.

If a claim is denied, AB will give written notice of:

1. the reason for denial; and
2. the policy provision that relates to the denial; and
3. the right to ask for a review of the claim; and
4. any additional information that might allow us to change our decision.

You may, upon written request, read any reports that are not confidential. For a small fee, AB will make copies of those reports for your use.

Termination of Coverage

See Plan Overview, When Coverage Ends section for further information.

APPEALS PROCEDURE

Prior to filing any lawsuit and within 60 days after denial of a claim, you or your beneficiary must appeal any denial of benefits under the policy by making a written request for review of the denial.

Employee Retirement Income Security Act of 1974

Information regarding your benefit rights mandated by ERISA can be found in the Plan Administration portion of the summary plan description.